New Hampshire

BYETTA® (exenatide)

First Health Services Corporation
A Coventry Health Care Company

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Does the patient have a diagnosis of Type 2 Diabetes Mellitus? ☐ Yes ☐ No

2. Is the patient 18 years of age or older? ☐ Yes ☐ No

3. Does the patient have a HgA1C level greater than 7 %? _____% ☐ Yes ☐ No

4. Has the patient tried and failed to attain adequate glycemic control on maximum tolerated doses of combination therapy of metformin and sulfonylurea, and/or thiazolidinedione? ☐ Yes ☐ No
   If the patient is not a candidate for one of the agents, then maximum tolerated doses of the individual agents is acceptable.

5. Is the patient currently taking insulin, alpha-glucosidase inhibitors (Precose®, Glyset®), or D-phenyalanine derivatives (Starlix®)? ☐ Yes ☐ No

6. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.
   _____
   _____

Section III: Prescriber Information:

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider